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Case Report

CASE REPORT

Transient femoral nerve neuropathy secondary to haematoma after medial thigh lift

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Abstract

We report an unusual and rare complication of transient femoral nerve neuropathy secondary to a large haematoma after medial thigh lift surgery. This has never been previously reported in the literature in association with this procedure. It is prudent to raise awareness that such a significant complication, although rare, can occur even with such a benign procedure, and that it is readily reversible with prompt recognition and early treatment.

INTRODUCTION

Iatrogenic femoral nerve neuropathy is a rare complication reported in the literature in relation to multiple various injuries. We report a first case of iatrogenic transient compressional femoral nerve neuropathy, that occurred secondary to a large haematoma after medial thigh lift surgery.

CASE REPORT

A 29-year-old woman underwent a medial thigh lift procedure 2 years after 30 kg weight loss sustained subsequent to gastric sleeve surgery, which gave her significant loose skin and tissue in the medial part of her upper thigh. After assessment, consultation and full consent, she agreed to undergo a medial thigh lift procedure, which involves a longitudinal scar arising from the inner groin area, vertically down to two-thirds of her upper medial thigh. A large ellipse of skin and fat was resected, after mobilisation of the excess skin almost to the anterior and the posterior thigh, followed by haemostasis, and closure with 2-0 vicryl, and 3-0 monocryl, without a drain. Venous vascularity was noted during the procedure, which was mainly dealt with by diathermy. Both thighs were treated in exactly the same manner. Post-operatively, a light compression garment was placed on the patient, and she was admitted to the ward for observation from 3 pm.

At ~9 pm that evening, the patient complained of tightness in the left thigh, greater than that on the right side. This was reported to the surgeon, who then instructed a firmer pressure dressing, and elevation of the left leg. By 9 am the next morning, the patient reported numbness over the anterior part of her left thigh, as well as the inability to move the left leg, both secondary to pain, and to weakness. The left leg was flexed at the knee and the hip, with external rotation of the hip, and with inability to both fully adduct the thigh (secondary to pain) or extend the knee. Physical examination found a moderate firm haematoma beneath the wound, filling up the dead space from the surgery, but no signs of active oozing. Due to the limited movement, pain and paraesthesia, an emergency evacuation of the haematoma was arranged. The patient arrived at the operating theatre at 11:30 am. Approximately 800 ml of tense blood clot was evacuated from the left medial thigh wound, of which the upper one-third had tracked up beneath the left groin flap laterally, pressing directly onto the femoral triangle. No active bleeding points were found, and the wound was washed with saline, a drain placed *in situ*, and the incision

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was closed in the same manner as previously. Dressings were applied with a firm crepe bandage as a pressure dressing. The leg was subsequently elevated overnight.

By 6 pm that evening, the patient reported significant improvement of the paraesthesia, and the pain. By 9 am the next morning, the patient had normal sensation in the anterior thigh, and normal movement of the left leg without much pain. She was able to stand up and slowly mobilise without any weakness.

DISCUSSION

Iatrogenic femoral nerve neuropathy is a rare complication described in the literature due to various injuries [1]. This has been previously reported secondary to total hip arthroplasty [2], pelvic haematoma, inguinal hernia repairs, gynaecological surgery [3] and even abdominoplasty [4]. We believe this is the first reported case in the literature of a transient femoral nerve palsy, occurring secondary to a tense haematoma after medial thigh lift surgery. Ordinarily, medial thigh lift surgery has a minor list of complications, with certainly no cases ever mentioned of femoral nerve palsy. It is prudent to consider this rare yet significant complication, especially with the treatment of any large haematomas in the vicinity of the femoral triangle. Of special significance to the occurrence of this complication in the first place, was that the large amount of skin that was removed had left a dead space over the area of the femoral triangle, which then allowed a tense haematoma to track and settle over this area, leading to the transient distress of the femoral nerve. The general rule that any new significant limb weakness or paraesthesia, in the presence of a significant-sized haematoma, should be actively treated by incision and evacuation, applied to this situation. It was indeed a relief to both the patient, and the surgeon, that the changes promptly resolved after actively evacuating the haematoma. Prompt recognition and treatment resulted in early resolution of the neuropathy and prevented a longer and more protracted course for recovery, or residual long-term weakness.

CONFLICT OF INTEREST STATEMENT

None declared.

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